

# Seminars in Health Care Delivery

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## A Practitioner's Guide to Treatment Selection in Psychiatry

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*This feature will appear regularly in The Western Journal of Medicine. It is intended to cover recent developments in a broad range of issues that will have an impact—either directly or indirectly—on clinical practice. Occasionally the seminars may include informed speculation about likely future developments.*

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Series' Editor

Psychiatry has changed dramatically during the past 20 years, probably as much as any other medical specialty. What had been largely a clinical art is now becoming very much a clinical science. A research rigor and creativity have informed all aspects of psychiatric investigation and practice. The basic neuroscience research carried out within psychiatry has become perhaps the most exciting of any basic science research in medicine.<sup>1</sup> A new and innovative classification system was introduced in 1980 and has for the first time provided for highly reliable psychiatric diagnoses.<sup>2</sup> Each of the psychiatric disorders is now defined by a list of operational diagnostic criteria, providing clear-cut algorithms to guide the process of differential diagnosis. Clinical outcome trials in psychiatry have become highly sophisticated in solving many of the technical design problems in patient selection, treatment delivery, process and outcome measurement and in providing meaningful controls.<sup>3</sup> A large number of psychiatric treatments have been developed and found to be effective.

As might be expected, the image of psychiatry has lagged far behind its actual pace of development. Many physicians were trained at a time when psychiatry was able to offer little more than a special insight into the physician-patient relationship and support for those who suffered with emotional illness. Moreover, for all kinds of reasons, psychiatry has also been a convenient topic for jokes and a target for disparagement. Such estrangement is certain to be resolved in the near future as psychiatrists establish their special areas of investigative, diagnostic and treatment expertise and as all physicians become aware of the advances that have occurred in the field and of their wider implications for medical practice.

This article provides a practical guide for psychiatric treatment selection for general medical practitioners. We

discuss the evidence for the efficacy of various psychiatric treatments, suggest the kinds of patients who might benefit from psychiatric treatment, what psychiatric treatments are available, who should deliver them and how one differentially selects from among the available possibilities in developing a treatment plan for a particular patient. Space constraints require that this be a brief overview; interested readers are referred to much fuller discussions of these topics that we have presented elsewhere.<sup>4-6</sup>

### The Efficacy of Psychiatric Treatments

The psychiatric literature now contains literally thousands of controlled-outcome studies. These can be grouped into several different categories. There is a vast literature documenting the effects of various kinds of medication for the various types of psychiatric disorder. The same Food and Drug Administration criteria that govern the development and testing of all other medications have been applied in testing the medications most commonly used in psychiatry—that is, the neuroleptic, antidepressant and anxiolytic drugs and lithium. The evidence from the many carefully controlled, double-blind studies is unequivocal. These medicines are definitely effective and relatively safe when used for appropriately selected patients. A rough average over thousands of trials with different drugs for different psychiatric conditions would probably result in a response rate of some 60% to 70% in those patients who receive medicine, whereas the placebo response tends to range from 20% to 40% (and lower for patients with schizophrenia).<sup>7</sup> Moreover, there are several different families of neuroleptic, antidepressant and anxiolytic drugs, and if patients fail to respond to a trial with any given drug, or experience intolerable side effects, they may still go on to have a good response with a different type of neuroleptic, antidepressant or anxiolytic.

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lytic drug. Thus, the overall and eventual response rate may be even higher in clinical practice than it is in research studies, presuming that the medications are prescribed in suitable doses for appropriate patients. The effectiveness of electroconvulsive therapy (ECT) as compared with antidepressants and with placebo—that is, sham ECT—has also been established in numerous studies. Perhaps most important is the fact that many depressed patients who have not responded to antidepressant medication will nonetheless go on to respond well to ECT.<sup>8</sup>

The second category of outcome study has been focused on determining the effectiveness of various forms of psychotherapy. Until recently this issue had been clouded by a polemic, and not particularly useful, controversy. Opponents of psychotherapy claimed it was ineffective with little or no evidence to support this contention, while proponents were enthusiastic about the benefits of psychotherapy with an equally scanty empiric foundation for their beliefs. During the past 20 years, more than a thousand controlled psychotherapy outcome studies were done, but until recently this literature was difficult to interpret because there was no convenient and unbiased method to review and collect data across studies.

This problem has now been solved with the development of a research review method known as meta-analysis. This method is based on using a simple but powerful statistic known as the effect size (computed by subtracting the change on any outcome measure in the control group from the change in the active treatment group and dividing by the standard deviation of change in the control group). It provides a change metric in standard deviation units that can be used to aggregate raw scores across studies. In a review of 475 controlled psychotherapy outcome studies, Smith and co-workers calculated effect sizes for some 1,700 different outcome measures.<sup>7</sup> Their meta-analysis showed that psychotherapy was significantly and substantially more effective than control alternatives (which consisted generally of being put on waiting lists or of nonspecific treatment contacts). In fact, patients at the 50th percentile in the treated groups had made sufficient gains so as to become as well off as patients in the 80th percentile of the untreated groups. Although it is elegant, the meta-analytic method is necessarily limited by the quality of the available studies, which were often done in a fashion that is not up to the current standards of design specificity.<sup>9</sup> Nonetheless, it seems clear from the findings that psychotherapy is an effective treatment.

There is an additional documentation of the efficacy of psychotherapy that will undoubtedly be of great interest to physicians. There is now fairly compelling evidence that psychotherapy produces definite benefits in the treatment of the medically ill, such as reducing morbidity and complications of a medical illness, increasing compliance with a needed treatment regimen and reducing the length of hospital stays and the number of required outpatient visits.<sup>10,11</sup>

The third category of outcome research in psychiatry compares the efficacy of psychotherapy versus medication versus combinations of psychotherapy and medications for the various psychiatric disorders in which both treatments might be used. This question has not yet been sufficiently studied and, in fact, is currently under investigation. None-

theless, the available data are very interesting. Smith and colleagues applied their meta-analytic method to drug and psychotherapy comparisons and discovered that the effects of combined treatments are greater than the effects of either treatment given alone, and, in fact, the effects of drugs and psychotherapy appear to be additive when these are given together.<sup>7</sup> The combination of medication and psychotherapy appears to be particularly effective in affective and schizophrenic disorders.<sup>12-14</sup>

### Who Should Be in Psychiatric Treatment?

There are several lines of evidence that suggest very clearly that many persons who would benefit from psychiatric diagnosis and treatment do not receive it. This is of special interest here because such persons do see nonpsychiatric physicians who are thus in a position to make crucial diagnoses of psychiatric conditions and to provide referral or treatment.

The most compelling data are from a recently conducted National Institute of Mental Health epidemiologic catchment area study carried out collaboratively in several different cities.<sup>14</sup> The study applied rigorous methods for identifying a randomly selected epidemiologic sample of the general community to make diagnostic decisions. Perhaps the most interesting finding of this massive study was that, across cities, there was a fairly high lifetime prevalence of anxiety (15%), affective disorders (8%) and substance abuse disorders (17%). Moreover, most of these persons with clear-cut and often very treatable psychiatric disorders had never received treatment for them.<sup>15</sup> Our own experience confirms this finding. Whenever there is a television program or a prominent newspaper article on anxiety or affective disorder, our clinic is likely to receive 100 or more phone calls from persons who have for the first time recognized that they have one of these disorders. They are more likely previously to have brought their complaints to nonpsychiatric physicians. It is thus crucial that nonpsychiatric physicians learn how to diagnose these conditions and either provide treatment themselves or arrange for referral.

Another line of supporting evidence that nonpsychiatric physicians see many patients who could benefit from psychiatric treatment is the consistent finding from many studies that as many as 50% of persons who present in general medical practice complain of symptoms that are primarily emotional in origin.<sup>16</sup> They often receive anxiolytic or antidepressant medication from their nonpsychiatric physicians, but very frequently this is provided with unclear indications and in doses that are inadequate. Many nonpsychiatric physicians need further training and experience on the indications for and ways of prescribing such drugs.

### What Psychiatric Treatments Are Available?

There are many different kinds of psychiatric treatments. These may be delivered in a range of settings (inpatient, outpatient, day hospital); for varying durations (such as consultations on one extreme, a lifetime follow-up on the other); in differing formats (individual, group, family), and with varied orientations (somatic, psychodynamic, cognitive, behavioral or interpersonal). To complicate matters even further, there are many viable permutations of all of these different possibilities. We can provide here only the briefest

overview of this diversity and will deal only with the various orientations.

The somatic orientation addresses the fact that many psychiatric disorders have a strong biologic component as evidenced by genetic loading, abnormal neuroendocrine and physiologic findings, abnormal responses to biologic challenge tests, positive responses to somatic treatment and, in a few instances, structural abnormalities revealed with sophisticated brain imaging tests. Effective somatic treatments (such as drugs) have been developed for schizophrenia and other psychotic disorders, unipolar and bipolar affective disorders, anxiety and eating disorders, some types of violence and some personality disorders.<sup>17</sup> Somatic treatments should always be delivered along with medical supportive psychotherapy to enhance compliance and the positive expectations that underlie the placebo effect.

The psychodynamic psychotherapies focus on clarifying the unconscious psychological conflicts that are responsible for some psychiatric symptoms and for many personality traits. A patient becomes more aware of the ways in which previously warded off and unacceptable wishes and fears are responsible for behaviors and symptoms. Such treatments can often be brief and focused (for instance, 12 sessions over 3 months), but if the goals are ambitious, they may require a greater frequency of visits (more than once a week) and a longer duration (a year or more). Psychodynamic treatments are particularly helpful in promoting character change.<sup>18</sup>

Cognitive therapies focus on the irrational, automatic thoughts that underlie many psychiatric disorders, such as the pessimism and self-criticism of depressive patients or the expectation of patients with anxiety disorders that something bad is always about to happen. A patient learns to identify these irrational thoughts as they occur, subject them to more rational inquiry and reverse the effects they previously had on feelings and behavior.<sup>19</sup> An offshoot of the cognitive approach has been the development of psychoeducational interventions that teach patients about their diagnosis, the physiology and psychology of their symptoms, the various treatment options and prognosis. Often psychiatric patients become secondarily demoralized about their symptoms, blame themselves for causing the problems and begin to feel hopeless. Learning that a disorder is well known, common and treatable is often a great relief and an important first step toward full participation in treatment and recovery.

Behavioral approaches operate on the assumption that symptoms result from the maladaptive reinforcement of self-defeating behaviors that can be unlearned by the teaching of new behaviors. Perhaps the most characteristic behavioral technique is systematic exposure to anxiety-producing situations. This often results in reducing both anxiety and phobic avoidance and in the development of much higher tolerance for whatever anxiety remains.<sup>20</sup> Behavior therapy for depression focuses on increasing a patient's pleasurable experiences. Other forms of behavior therapy include assertiveness training, role modeling and contingency contracting. Behavioral and cognitive techniques are increasingly being combined within one treatment package. These methods usually require from 10 to 40 sessions.

Interpersonal psychotherapies focus on the power of the therapeutic relationship to support a patient through stressful times and also to help the patient to change pathologic styles

of interaction. Interpersonal difficulties that occur outside of treatment can be explored and related to interpersonal patterns that develop within the treatment. A therapist attempts to behave toward the patient in a way that will model and pull for new and more adaptive styles of interaction.<sup>21</sup> Interpersonal methods can be delivered within the individual format but are also particularly suited to marital and group psychotherapies.<sup>22</sup>

Most psychotherapists provide some combination of the different models we have just described, but are particularly expert in just one or two of them. In making referrals, it is useful to know something about a therapist's training, experiences and orientation to match these with a patient's particular problems and goals. We will discuss referral options in more detail in the next section.

### **Who Should Provide Psychiatric Treatment for Patients?**

The question of who should provide psychiatric treatment for patients is a highly controversial one with important quality-of-care and financial implications. In current practice, patients in need of psychiatric care are treated by psychiatrists, nonpsychiatric physicians, psychologists, social workers, nurses, activities therapists, marriage counselors, pastoral counselors and, in some states, by persons with no special training or discipline at all who yet claim to be psychotherapists. This situation is confusing to both practitioner and patient. We will attempt to articulate an approach to this question that makes sense to us but which may not work or apply in all situations or make sense to those who have a background different from ours.

Nonpsychiatric physicians who look for them will almost certainly find many patients who suffer from depression, anxiety, somatization disorder, substance abuse and other psychiatric disorders that are severe enough to warrant a treatment intervention. Those nonpsychiatric physicians who have a special interest, and who have received training, in the management of one or more of these conditions may be quite effective in providing the first line of treatment themselves (usually medication and a medically oriented supportive psychotherapy). A consultation with a psychiatrist may be useful at the onset of treatment and is certainly indicated for all of those patients who do not respond to treatment or in whom side effects or complications develop. Even the majority of nonpsychiatric physicians who will refer most or all such patients elsewhere for treatment must have enough training and experience to make the diagnosis that a psychiatric problem is present and that a referral is indicated for further diagnosis and treatment.

For patients who will require medication, the choice of practitioner is fairly straightforward—it will generally be either a psychiatrist or nonpsychiatric physician. For patients receiving psychotherapy, the choice may seem bewildering and spans all of the professions (and even nonprofessions) mentioned earlier. It is often wise to have a psychiatric consultation at the beginning of treatment to determine that medication is not indicated. Beyond this there are few clear guidelines in choosing the discipline of a psychotherapist. The individual personality characteristics, special training and experience of the people involved may be more crucial than the particularities of discipline. It is generally wise to

refer to persons who have received formal training in psychotherapy and who are certified in their discipline. It is also a good practice to check with colleagues to identify therapists with good track records. Patients who have previously been referred can be a good source of information about the styles and results of the therapists they have seen. Fringe therapists and therapies are best avoided.

### Differential Therapeutics in Psychiatry

The topic of differential therapeutics in psychiatry is complicated by the fact that a number of different treatments in psychiatry have shown efficacy for the various major syndromes and there is not yet extensive literature indicating which treatment or treatment combinations work particularly well in which situations. One encouraging implication of this is that if one treatment does not work, there is likely to be another available that will. The following is necessarily a telegraphic and impressionistic overview.

The treatment of schizophrenic disorders usually requires a long-term (perhaps lifelong) follow-up. Treatment with medication is necessary for all acute episodes. There is some debate whether medication should be withheld or reduced between episodes in selected patients to reduce the risk of tardive dyskinesia. This is now a subject of intense study. Further, there is good evidence that behavioral family therapy, designed to teach problem-solving skills and to reduce hostile interactions, has a substantial impact in reducing relapse rates.<sup>23</sup> Various forms of rehabilitation therapy also appear promising.

Lithium is the most valuable medication in reducing the cyclicity of bipolar disorder and for the treatment of acute mania. Antidepressants are often necessary to give in conjunction with lithium in treating the depressive phase of bipolar disorder, and it is occasionally necessary to administer neuroleptic agents or electroconvulsive therapy in the short-term management of a manic phase. Manic patients generally cannot be treated outside of the hospital unless their symptoms are mild and there are unusually strong family supports. Psychotherapy of various sorts may be helpful between episodes to identify and help deal with the psychosocial stressors and the personality factors that may predispose to acute episodes. Psychotherapy may also be helpful for the acute depressions associated with bipolar disorder, if these are not severe.

Antidepressant drugs are more useful for the management of severe melancholic depressions and often hospital admission is necessary. Patients with delusional depression respond best to combinations of antidepressants and neuroleptics or to ECT. Various types of outpatient psychotherapy (particularly cognitive and interpersonal) appear to be very helpful for mild to moderate depression. Patients who have vegetative symptoms of depression or who do not respond sufficiently to psychotherapy may show additional benefit with a combination of antidepressants and psychotherapy.

Patients with panic disorder with and without agoraphobia respond to antidepressant medications, to behavioral therapies and to a combination of these. The choice among these types of treatment depends most on patient and physician preferences. Medications require prolonged use and may result in withdrawal relapses, but behavior therapy requires more in the way of patient motivation and a willingness to

enter into feared situations. Anxiolytic drugs are effective for generalized anxiety disorder but carry an appreciable risk of tolerance and abuse in this population. Behavioral, cognitive and psychodynamic therapies appear to be beneficial for generalized anxiety, but this has not yet been established. Obsessive-compulsive and eating disorders respond to both antidepressant medications and behavior therapy, and it is not yet clear when to choose one approach or the other, or a combination.

The milder personality disorders are most often treated with psychodynamic approaches, although cognitive, behavioral and interpersonal approaches also show promise. There are very tentative suggestions that medications may sometimes be helpful for patients with schizotypal and borderline personality disorder.

Issues having to do with the choice of the setting, duration and format of psychiatric treatment are beyond our scope here and have been discussed elsewhere in considerable detail.

### Conclusions

Psychiatric disorders—particularly anxiety, affective, substance abuse and personality disorders—are commonly encountered in general medical practice. Advances in psychiatric classification have taken the mystery and unreliability out of psychiatric diagnosis. Because simple and effective treatments exist for many of these disorders, it is incumbent on medical practitioners to become familiar with the psychiatric diagnostic criteria of those psychiatric cases that are most often encountered in their practices. It can be just as serious a medical mistake to miss a diagnosis of depression (with its 10% lifetime suicidal rate) or panic disorder (with its frequent complication of agoraphobia) as it is to miss congestive heart failure or an enlarged spleen. Those physicians who prescribe psychiatric drugs (neuroleptics, antidepressants, anxiolytics, lithium) should—and often do not—have sufficient training on their indications, dosage regimen and side effects to use them intelligently. Without such training, psychiatric referral at least for consultation increases the chance that a patient will receive up-to-date treatment. Psychotherapy has documented its efficacy and is useful in treating patients with a variety of psychiatric diagnoses, stress response syndromes, personality problems and miscellaneous problems in coping.

Psychiatry has recently developed a strong foundation in clinical and basic science and has drawn closer in its methods and attitudes to the other specialties of medicine. This has already benefited psychiatry greatly and will undoubtedly also benefit the rest of medicine as soon as recent advances in psychiatry become part of common medical knowledge.

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